MEDICAL RECORD	Orders Manual: Outpatient Clinic 13 (Rainbow Clinic)

Date: _____ **Protocol #:** _____ **Week:** _____ **# of Visit Days:** _____

Appointment Dates: _____ ☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

CLINIC VISIT		**Date**	**Time**
Clinical Center Lab	Non-Clinical Center Labs		
☐ Lab Work	☐ Lab Work		
☐ Monitoring labs per protocol roadmap	☐ PKs		
☐ Urine for pregnancy	☐ Routine FACS		
☐ 24 hour urine (specify start date)	☐ Extended FACS		
☐ HIV RNA/PCR	☐ Viral Resistance		
☐ Fasting labs, specify	☐ Other (specify)		
☐ Other (specify)	☐ Other (specify)		
☐ H&P ☐ am ☐ pm *Provider (specify):*			
☐ Family Meeting ☐ Sign consent			
☐ Social Work *Provider (specify):*			
☐ Research RN *Provider (specify):*			
☐ Ancillary Procedures			
☐ Clinic nurse adherence assessment ☐ Protocol patient teaching Provider (specify):			
☐ Drug accountability (pill count) ☐ Protocol adherence assessment/interview Provider (specify):			
☐ Skin test placement (specify date) ☐ Protocol psychosocial assessment Provider (specify):			
☐ Read skin tests 48 hours after placement			
☐ IVIG			
☐ Other (specify)			
IMAGING STUDIES			
☐ CT ☐ head ☐ With contrast on Day 2 (NPO for 4 hours)			
☐ thymus w/thymic volume ☐ With contrast on Day 2 (NPO for 4 hours)			
☐ chest ☐ With contrast on Day 2 (NPO for 4 hours)			
☐ abdomen/pelvis ☐ With contrast on Day 2 (NPO for 4 hours)			
☐ Other (specify) ☐ With contrast on Day 2 (NPO for 4 hours)			
☐ Ultrasound (specify area) ☐ NPO for 4 hours			
☐ Chest X-ray ☐ Echocardiogram ☐ EKG			
☐ MRI (specify area)			
☐ Bone age (x-ray)			
☐ DEXA (specify machine)			
☐ Other (specify)			
CONSULTS / OTHER			
☐ Audiology	☐ Ophthalmology		
☐ Dental	☐ Occupational Therapy		
☐ Dermatology	☐ Physical Therapy		
☐ GI	☐ Psychiatry		
☐ Neuropsychology	☐ Rehabilitation		
☐ Neurology (Dr. Civitello)	☐ Speech		
☐ Nutrition	☐ Other (specify)		

Appointment Information:

☐ Plane ☐ Train ☐ Car (mileage: _____)

☐ Children's Inn ☐ Hotel ☐ Guest House ☐ Local ☐ Other

Arrive: _____ Depart: _____

Food Voucher: ☐ Yes ☐ No Dates: _____

Guardian: ☐ Yes ☐ No

Voucher completed by:

Was this visit rescheduled from another date? ☐ Yes ☐ No

If yes, what date was the previous visit scheduled for? _____

Reason visit was rescheduled, if known: _____

LIP Signature	LIP Name (printed)	Date